Health Care Licensing Application
Assisted Living Facility -
Renewal Licensure

Provider/Facility Information

Under the authority of Chapters 408, Part II and 429, Part I Florida Statutes (F.S.), and Chapters 59A-35 and 59A-36, Florida Administrative Code (F.A.C.), an application is hereby made to operate an assisted living facility as indicated below.

Pursuant to sections 408.806 (1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number of the applicant, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory.

The Agency for Health Care Administration (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address and telephone number will be listed on Florida Health Finder (http://www.floridahealthfinder.gov).

Provider/Facility Information

License Number: 11224 National Provider Identifier: 1619298593 Medicare Number:

File Number: 11967162 Medicaid Number: [redacted]

Provider/Facility: AMOR DE JESUS, CORP

Provider/Facility Location Address

Street Address: 14283 SW 177 STREET (Bld, Suite, Floor, Villa, Apt)

City: MIAMI State: FLORIDA Zip: 33177

County: MIAMI-DADE

Telephone: (786) 429-1087 Telephone Ext: Fax: (786) 364-1526

Provider Website: None Email Address: avaleria197601@gmail.com

Provider/Facility Mailing Address (All mail will be sent to this address)

Street Address: 14283 SW 177 STREET (Bld, Suite, Floor, Villa, Apt)

City: MIAMI State: FLORIDA Zip: 33177

County: MIAMI-DADE Telephone: (786) 429-1087 Telephone Ext:

Email Address avaleria197601@gmail.com

Contact Person

Provider/Facility Contact Person for this application

Contact Person: AMINTA QUINONEZ Suffix:

Telephone: (786) 201-4302 Telephone Ext: Fax: None

Email: avaleria19601@gmail.com

***Note**: By providing your email address you agree to accept email correspondence from the Agency*

Property Ownership

Does the licensee own or lease this facility? If leased, you may provide the name of the property owner by following the instructions below.

☐ Own ☒ Lease

Full Name of Individual/Entity JOSE M MACHADO

Effective Date: 09/17/2012 End Date:

Mailing Address

Address Type: Personal

Street Address: 14935 SW 297TH ST (Bld, Suite, Floor, Villa, Apt):

City: HOMESTEAD State: FL

Zip: 33033-3701 County: MIAMI-DADE

Telephone: (786) 201-1499 Telephone Ext.:

Email: jnm0304@yahoo.com

Licensee Information

Licensee Details

Description of Licensee: For Profit Ownership Type: Corporation

Licensee Name: AMOR DE JESUS, CORP FEIN: [redacted]

Mailing Address: 14283 SOUTH WEST 177 STREET (Bld, Suite, Floor, Villa, Apt.)

City: MIAMI State: FLORIDA Zip: 33177

County: MIAMI-DADE

Telephone: (789) 429-1087 Telephone Ext: Fax: (786) 364-1526

Email: avaleria197601@gmail.com

Controlling Interest of Licensee

Controlling Interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651. F.S. To verify who must be screened, visit the Background Screening site.

Person and/or Entity Ownership of Licensee

Do any individuals or entities possess 5% or greater ownership interest in the licensee or function as a board member or officer? Y

Full Name of Individual/Entity:	JOSE N MACHADO	SSN/EIN:	xxx-xxx-xxxx
Board Member/ Officer:	YES	Suffix:	
% Ownership:	100.00		
Effective Date:	09/17/2012	End Date:	
Mailing Address Type:	Business		
Street Address:	2135 SW 156 COURT	(Bld, Suite, Floor, Villa, Apt)	
City:	MIAMI	State:	FL
Zip:	33185	County:	MIAMI-DADE
Telephone:	(305) 552-7559	Telephone Ext.:	
Email:	jnm0304@yahoo.com		

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

Does a company other than the licensee manage the licensed/registered provider? N

Management Company Controlling Interest

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Note: For the administrator and financial officer, an AHCA Screening through the Care Provider Background Screening Clearinghouse (Clearinghouse) is needed, or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Please Note: An Administrator may only represent up to three (3) Assisted Living Facilities.

Administration

First Name: AMINTA Middle: Last Name: QUINONEZ

Suffix: SSN: xxx-xxx-xxxx [redacted]

Address Type:

Street Name or P.O. Box: 15505 SW 16 LANE (Bld, Suite, Floor, Villa, Apt.):

City: MIAMI State: FLORIDA

Zip: 33185 County: MIAMI-DADE

Telephone: (786) 201-4302 Telephone Ext:

Email: avaleria197601@gmail.com

Title	Effective Date	End Date	FL License Number
Administrator / Managing Employee	7/13/2012		

First Name: JOSE Middle: N Last Name: MACHADO

Suffix: SSN: xxx-xxx-xxxx [redacted]

Address Type: Business

Street Name or P.O. Box: 2135 SW 156 COURT (Bld, Suite, Floor, Villa, Apt.):

City: MIAMI State: FLORIDA

Zip: 33185 County: MIAMI-DADE

Telephone: (305) 552-7559 Telephone Ext:

Email: jnm0304@yahoo.com

Title	Effective Date	End Date	FL License Number
Financial Officer	9/17/2012		

Safety Liaison

Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S.

First Name: AMINTA Middle: Last Name: QUINONEZ

Effective Date: 07/13/2012 End Date:

Phone: 7862014302 Telephone Ext:

Address line1: 15505 SW 16 LANE Address line2:

City: MIAMI State: FL Zip: 33185

Email: avaleria197601@gmail.com

Required Disclosures

Convictions

Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.? N

Exclusions

Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? N

Felonies / Terminations

Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud or insurance fraud, within the previous 15 years prior to the date of this application? N

Terminated for cause from the Medicare program or a state Medicaid program? N

Health and Residential Care

In the past 5 years, has the applicant or any controlling interest owned any entity that provided health or residential care in Florida or any other state? N

If yes, has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it?

Miscellaneous

Provide the following information for the requested positions:

Does the owner, administrator, or any facility representative serve as 'representative payee' or as power of attorney for any Assisted Living Facility residents? N

Representative Payee is an individual or entity who receives payments on behalf of a resident (i.e., social security benefits, supplemental social security, or optional state supplementation). A resident must give consent for an owner, administrator, or facility representative to act as their representative payee or power of attorney.

If yes, provide a copy of the Surety Bond in the Supporting Documents section of this application.

Is the Assisted Living Facility a part of a continuing care retirement community (CCRC) pursuant to Chapter 651, F.S.? N

If yes, attach a copy of your Certificate of Authority in the Supporting Documents section of this application.

Does the Assisted Living facility participate in Long Term Care, Managed Care, or MMA (Managed Medical Assistance).? Y

If yes, provide your Medicaid number below.

Medicaid #: [redacted]

Do you offer or do you plan to offer adult day care services in your assisted living facility? Y

Bed Count

Enter/Verify the number of beds by bed type below.

# Private Pay Beds:	0
# OSS Beds:	6
Total Capacity:	6

Consumer Information

The following information is provided for consumers through the Florida Health Finder website.

Room Type:

☒ Occupancy	6
☒ Private Beds	0
☒ Semi-Private Beds	3
☒ Bed Hold ?	Yes

Facility's Religious Affiliation (if any):

Payment Forms Accepted:

- ☒ Insurance/ HMO
- ☒ Medicaid
- ☒ Veterans Administration
- ☒ Other:Cash or Checks

Special Services:

Languages Spoken by Administrator and Staff:

- ☒ English
- ☒ Spanish

Nurse Availability:

- ☒ None

Special Program:

- ☒ Arts and Crafts
- ☒ Dancing
- ☒ Exercise Class
- ☒ Games/Cards

Qualifications

1. Identify the type(s) of specialty licenses currently held or being pursued with this application.

- ☐ None
- ☒ Limited Mental Health (LMH)
- ☐ Limited Nursing Services (LNS)
- ☐ Extended Congregate Care (ECC)

Attestation

I **JOSE MACHADO** , attest as follows:

(1) Pursuant to section 837.06, Florida Statutes I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

(2) Pursuant to section 408.815, Florida Statutes I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.

(3) Pursuant to section 408.806, Florida Statutes, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to section 408.809 and 435.05, Florida Statutes every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II and Chapter 435, Florida Statutes and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

(6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure; who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

JOSE MACHADO	OWNER	01/16/2023
Signature of Licensee or Authorized Representative	Title	Date